

THE AFFORDABLE CARE ACT



GUIDE







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Purpose of this Guide

The purpose of this guide is to outline the provisions in an easy to read manner.

Please note that regulations are continuously being released, so information in this guide could change without notice. We put this guide to share with our clients and friends to use for informational purposes only. Clients should consult their lawyer and accountant for final guidance.

Overview

The **Affordable Care Act** (ACA) formerly referred to as the Patient Protection Affordable Care Act (PPACA), was signed into law by President Obama on March 23rd, 2010.

It contains a set of comprehensive health insurance reforms that will be implemented in stages, starting in 2010 and continuing over the next few years. The majority of provisions of the ACA are going into effect starting January 1st, 2014.



SUPREME COURT DECISION

On June 28th, 2012

The Supreme Court ruled on the constitutionality of the individual mandate, which forces an individual to have insurance coverage or face a penalty.

Twenty six states' Attorney Generals sued the Federal Government, saying that forcing a private individual to buy a private product simply by living was unconstitutional.

Justice John Roberts sided with the liberal side of the bench and ruled that the penalty was in fact a tax, and therefore could be levied under Congress' power to tax

This was the law's last hope of being repealed through the court system. The only other option of repeal was through the legislative branch, and with the democratically controlled Senate and Executive branch, this was not a possibility, so the law is here to stay for now.



Grandfather Status

If a plan was written before March 23rd, 2010 and makes no material changes to benefit:

- » The plan can remain grandfathered and does not have to abide by all the provisions in the ACA (some provisions still apply to grandfathered plans, we will outline those later.)

Material Change

If a plan decreases benefit by more than **15%** (plus annual medical inflation), it will lose its grandfathered status.

In both the individual and group market, there are really no benefit changes that would be less than **15%**. This means, if an individual or group decreases benefits at all, it would be by more than **15%**, and result in a loss of grandfathering status.

In the group market, the second provision a plan had to follow to remain grandfathered had to do with employee contributions. An employer could not increase employee contributions by more than **5%** since March 23rd 2010. If they did, they would lose their grandfather status.

**<http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html>

Grandfather Status

Plan written
before
March 23, 2010



No material
changes

Non-Grandfather Status

Plan decreases
benefit more
than 15%



Employer
cannot
increase
employee
contributions
more than 5%



Six Month Reform Changes

Effective September 23rd, 2010,

Five reforms were enacted and dubbed, "Six Month Reforms" for their timing. Below is a chart to show the reform, whether it applies to grandfathered plans or non-grandfathered plans, and whether the provision applies to the group or individual market.

Reform Chart

Six Month Provision	Non-Grandfathered		Grandfathered	
	Group	Individual	Group	Individual
Lifetime Limits: Prohibits life-time maximum caps	●	●	●	●
Annual Limits: Restricts annual maximum benefits for certain services. Therapy, Occupational, Speech Therapy	●	●	●	
Child Pre-Ex: Prohibits pre-ex waiting period for children under 19.	●	●	●	
Preventative Care: Provides coverage for defined preventative services.	●	●		
Dependent Age Increased to 26	●	●	●	●



Lifetime Limits

Before ACA

Some insurance plans would set a lifetime limit on the amount of benefit they would pay out per person.

As of September 23rd, 2010:

All new plans, or plans renewing on or after this date will no longer have a lifetime limit applied. *This provision applies to group and individual plans both grandfathered and non-grandfathered.*

**<http://www.healthcare.gov/law/features/costs/limits/>

Child Pre-Existing Condition Clause



**Children under the age of 19
Cannot be denied for medical conditions and will have no pre-existing waiting period on any health benefits.**

Annual Limits

Group and individual non-grandfathered plans and group grandfathered plans written on or renewing after September 23rd, 2010, will be phasing out the Annual Limits for certain benefits. The law states that a plan cannot set an annual limit lower than....

» \$750,000

For a plan year starting on or after September 23, 2010 but before September 23rd, 2011.

» \$1.25 Million

For a plan year starting on or after September 23rd, 2011 but before September 23rd, 2012

» \$2 Million

For a plan year start on or after September 23rd, 2012 but before January 1st, 2014.

No Annual Dollar Limits are allowed on most covered benefits starting January 1st, 2014.

**<http://www.healthcare.gov/law/features/costs/limits/>

What is a pre-existing waiting period?

A period of time a person may have to wait for a certain health condition to be covered if they have gone without insurance coverage for more than 63 days (per HIPAA law). This provision applies to individual and group non-grandfathered policies and group grandfathered policies. It does not apply to grandfathered individual policies.

**<http://www.regulations.gov/#!documentDetail;D=HHS-OS-2010-0014-0001>

**<http://www.healthcare.gov/law/features/rights/childrens-pre-existing-conditions/>



PREVENTATIVE CARE



All non-grandfathered policies, group and individual will have **100% coverage on defined preventive services for plans written or renewing on or after September 23rd, 2010.**

Preventative services are defined by the United States Preventive Task Force Service (<http://www.uspreventiveservicestaskforce.org/>).

In order to
be covered at
100%
The service must be
classified as a
TYPE A or **TYPE B**
service.



Examples of Services Classified as Preventive

- Blood Pressure Screening
- Cholesterol Screening
- Colorectal Cancer Screening for adults over 50
- Type 2 Diabetes screen for adults with high blood pressure
- Immunizations such as Flu shots, Pneumonia, tetanus, and others
- Obesity Screenings
- STD prevention and counseling for adults at high risk
- Tobacco Use screening and cessation interventions

A complete list of adult wellness services can be found by visiting the following website: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults>



Women Preventive Services



Women's preventive care was added to the coverage for policies effective on or renewing after August 1st, 2012.

Included in the preventive women's coverage is....

- ▶ Breast cancer screening every 1 to 2 years for women over 40
- ▶ Breastfeeding support and counseling as well as accessing to breastfeeding supplies
- ▶ Cervical cancer screening
- ▶ Sexually Transmitted Infections counseling
- ▶ Well women visits
- ▶ Certain Contraceptive drugs and sterilization procedures not including abortifacient drugs

A complete list of women's preventive services can be found by visiting the following website: <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html>



Children Preventive Services



Children also have a separate list of services that are classified as preventive. Below is a partial list of those services.

- ▶ Autism screening for children at 18 and 24 months
- ▶ Behavioral assessment for children of all ages
- ▶ Developmental screen for children under age 3
- ▶ Depression screen for adolescents
- ▶ Hearing screens for newborns
- ▶ Immunizations including but not limited to Hepatitis A & B, HPV, Flu shot, Measles, Mumps, Rubella, Pneumonia
- ▶ Obesity Screenings
- ▶ Vision Screenings

To see a complete list of preventive services for children, visit the following website:
<http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults>

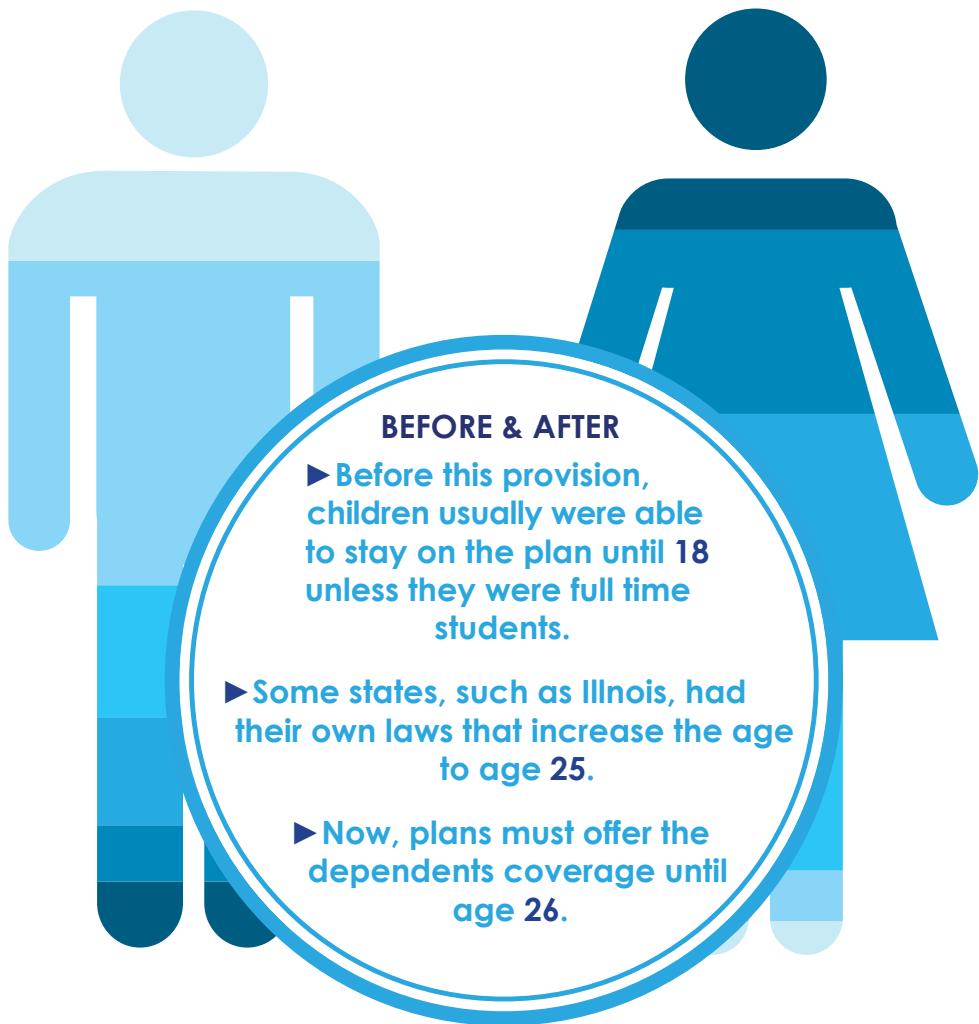


Dependent Age Increased to 26

All plans effective or renewing after September 23rd, 2010 have an increased dependent age of 26.

This applies to grandfathered and non-grandfathered

Group & Individual



Children can stay on the plan...

- ▶ If they are married
- ▶ If they do not live with the parents
- ▶ Regardless of student status
- ▶ Not financially dependent on the parent
- ▶ If they are eligible to enroll in an employer's plan*

*Grandfathered group plans do not have to offer coverage to dependents who are offered coverage through their job until January 1st, 2014.

**<http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html>



Medical Loss Ratio (MLR)

Effective January 1st, 2011



All carriers must allocate .80 cents of every premium dollar for the Small Group (2-99 lives) and individual market, and .85 cents for every premium dollar for the large group market to pay claims. The rest is used for administration costs.

Small Group
(2-99 lives)
& Individual Market

Large Group Market

PREMIUM \$1.00
-\$0.80
-\$Admin Costs

PREMIUM \$1.00
-\$0.85
-\$Admin Costs

Calculation to see if the carrier met this ratio is done the following year. If it is determined that the carrier did not meet MLR, the carrier must issue rebate checks to policyholders. They will issue the checks in the proportion of the premium paid and the overall book of business. Groups that receive a rebate should consult with their accountant on how the rebate is to be refunded.

IRS FAQ on MLR: [http://www.irs.gov/uac/Medical-Loss-Ratio-\(MLR\)-FAQs](http://www.irs.gov/uac/Medical-Loss-Ratio-(MLR)-FAQs)
DOL Release on Group Distributions of Rebates: <http://www.dol.gov/ebsa/newsroom/tr11-04.html>

FILED
MORE THAN
250+

Employers will look at the number of W-2's they filed for tax year 2011. If they filed more than 250, they are subject to this provision in 2012.

FILED
LESS THAN 250

If they filed less than 250 W-2's in 2011, they are not subject to this provision until further guidance is issued.

Certain employers will have to report the aggregate amount of employer sponsored group health benefits on an employee's W-2.

The first year this is required is tax year 2012, which are issued in January 2013.

W-2
Reporting

It's important to note that reporting the amount of health benefits on the W-2 does NOT treat those benefits as taxable income. They are reported for informational purposes only and are not added to the employee's taxable wages.



Changes to HSA's & FSA's under ACA



Effective January 1st, 2011

Withdrawals from an HSA account for non-qualified medical expenses will face a **20%** penalty

20%
penalty

This is opposed to the **10%** penalty that was in effect prior to this change.



Also effective January 1st, 2011 is the establishment of a new qualified medical expense list to remove over the counter medications unless the patient has a prescription.

*****The rule does not apply to insulin.

Starting January 1st, 2013

The limit for the medical expense portion of the FSA was set at **\$2,500** per employee.

Note:

- This does not include the childcare provision or POP plan provision.
- Previously, there was no limit to the medical portion of the FSA and it was up to the employer to set the limit.

** FSA/HSA <http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs>

** FSA IRS Bulletin: http://www.irs.gov/irb/20129-26_IRB/ar09.html



Summary of Coverage: What this Plan Covers & What it Costs		Policy Period: _____	Coverage for: _____ Plan Type: _____
Common Medical Event	Services You May Receive	Summary of Coverage: What this Plan Covers & What it Costs	
immediate medical attention	Emergency medical care Urgent care	Summary of Coverage: What this Plan Covers & What it Costs	
If you have a hospital stay	Facility fee (e.g. Physician/surgeon fee)	Summary of Coverage: What this Plan Covers & What it Costs	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health/Substance Use/Substance Abuse	Summary of Coverage: What this Plan Covers & What it Costs	
If you become pregnant	Prenatal and postpartum care Delivery and complications	Summary of Coverage: What this Plan Covers & What it Costs	
If you have a recovery or other special health need	Hospital care Rehabilitation Habilitation services Skilled nursing Dialysis Home health care	Summary of Coverage: What this Plan Covers & What it Costs	
If your child needs dental or eye care	Eye exam Glasses Dental checkups	Summary of Coverage: What this Plan Covers & What it Costs	
Excluded Services & Other Limitations			
Services Your Plan Does NOT Cover			
* Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.			
Summary of Coverage: What this Plan Covers & What it Costs			
Common Medical Event		Services You May Receive	
If you visit a health care provider's office or clinic	Primary care visit to Specialist visit Other practitioner or physician visit Prescriptive care/visit	Summary of Coverage: What this Plan Covers & What it Costs	
If you have a test	Diagnostic test (e.g., Imaging (CT/PET etc.) Genetic tests Preferred brand drugs Non-preferred brands	Summary of Coverage: What this Plan Covers & What it Costs	
If you need drugs to treat your illness or condition	Specialty drugs (e.g., biologics/monoclonal antibodies/prescription drugs)	Summary of Coverage: What this Plan Covers & What it Costs	
If you have outpatient surgery	Facility fee (e.g., Physician/surgeon fee)	Summary of Coverage: What this Plan Covers & What it Costs	
If you need emergency room care	Emergency room visit	Summary of Coverage: What this Plan Covers & What it Costs	
Important Questions			
What is the premium?	\$	Why this Matters: The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.	
What is the overall deductible?	\$		
Are there other deductibles for specific services?	\$		
Is there an out-of-pocket limit on my expenses?	\$		
What is not included in the out-of-pocket limit?			
Is there an overall annual limit on what the insurer pays?			
Does this plan use a network of providers?			
Do I need a referral to see a specialist?			
Are there services this plan doesn't cover?			
<small>Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.</small>			

Summary of Benefit & Coverage

The Summary of Benefit and Coverage, often referred to as an **SBC**, is a standardized highlight sheet for all plans, group and individual, grandfathered and non-grandfathered. These **SBC's** must be given to enrollees....

- ▶ Upon enrollment
- ▶ At renewal
- ▶ 60 days prior to an off renewal plan change
- ▶ Upon request

Some group carriers require off-renewal plan changes to be submitted at least 60 days in advance of the effective date to ensure that the employees have been given the SBC on time. Please check with your carrier for more information on off-renewal plan changes.

[**http://www.dol.gov/ebsa/faqs/faq-aca8.html](http://www.dol.gov/ebsa/faqs/faq-aca8.html)



Employer Requirement to Provide Health Insurance

Starting January 1st, 2015

Employers with more than 50 Full Time Equivalent (FTE) employees who do not provide essential minimum health coverage to all full time employees will face a fine.

Full time is defined in the ACA as 30 hours or more a week.

The
“No Coverage Fine”
is \$2,000 per
full-time employee not
counting the
first 30.

For example, an employer with 70 full time employees would be fined (70-30) x \$2,000= \$80,000 annually.

Groups with under 50 FTE's will have no financial penalty for not providing coverage.



Shared Responsibility Fine

Starting January 1st, 2015,

- If an employer who is over 50 FTE's provides coverage, and the employee only portion of premium exceeds 9.5% of that employee's annual household income, that employee is eligible for a tax subsidy to purchase individual coverage.
- If the employees choose to take that subsidy and purchases insurance individually, the employer will be fined

FINES

\$3,000 for every employee that is receiving a tax credit or...

\$2,000 per full time employee not counting the first 30 employees

The employer will be assessed the lesser of the two fines...

**<http://www.shrm.org/hrdisciplines/benefits/Documents/EmployerPenalties.pdf>



FULL TIME EQUIVALENT EQUATION



The full time equivalent equation was created to determine if an employer is over or under 50 FTE's for purposes of determining if that employer is subject to a fine for not providing coverage. The equation not only counts your full-time employees, but takes into account your part time employees as well. The basic concept is that two part time employees working 15 hours a week count the same towards the equation as one full time employee working 30 hours a week.

The Equation

- A. Sum the total number of hours worked by all part time employees in a given month: _____
- B. Divide by 120: /120
- C. This is the number of Full Time Equivalents your Part Time Employees Add to: _____
- D. List the number of full time employees that work more than 30 hours a week:

- E. Add lines C & D to get the total FTE's for your group: _____



- If E is over 50 ► the group is subject to the fine if they do not provide coverage.
- If E is under 50 ► the group does not face a fine if they do not provide coverage.

To determine what month to use for this equation and how to measure each individual employee's full time vs. part time status when you have fluctuating hours, please refer to the below link and consult an accountant and lawyer.

**<https://www.federalregister.gov/articles/2013/01/02/2012-31269/shared-responsibility-for-employers-regarding-health-coverage>



Automatic Enrollment 2014

In 2014,
Groups with over 200
full time employees
must automatically
enroll those employees
in the health plan.



They must provide adequate time for those employees to opt out if they wish to do so.

**<http://www.shrm.org/hrdisciplines/benefits/Documents/EmployerPenalties.pdf>



Effective January 1st, 2014

The maximum waiting period allowed on all groups, grandfathered and non-grandfathered, will be 90 calendar days.

**<http://www.shrm.org/hrdisciplines/benefits/articles/pages/aca-full-time-employees.aspx>



ESSENTIAL HEALTH BENEFITS

New plans written January 1st, 2014, or plans renewing on or after that date, will have to include essential health benefits (EHB).



This applies to non-grandfathered group and individual plans.

While most of these coverages are already included on group policies, for some individual policies, this could be a significant increase in benefits.

**<http://ccilio.cms.gov/resources/fact-sheets>



BENEFITS

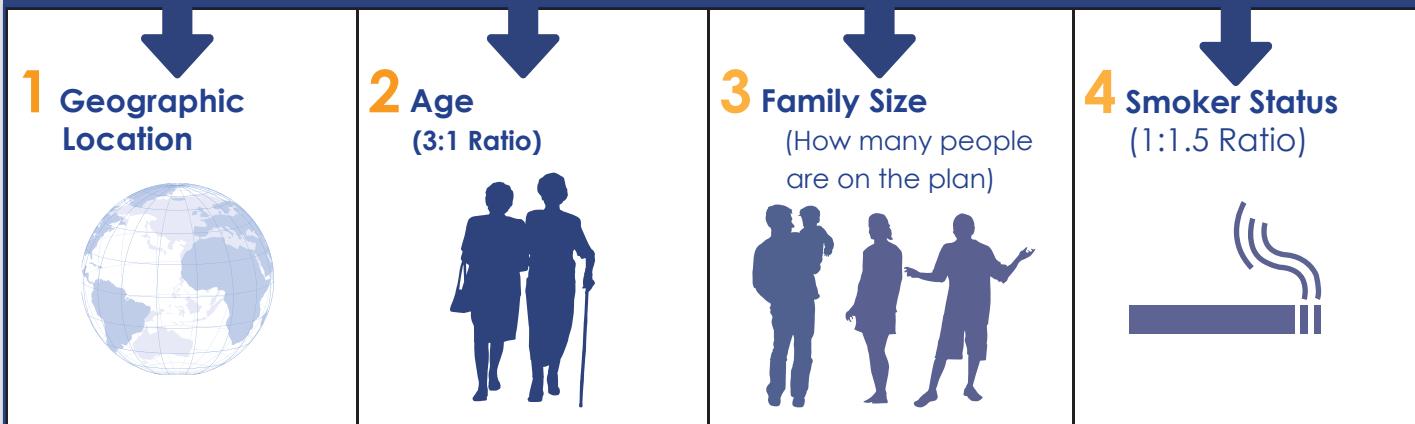
Essential Health Benefits include

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices.
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Community Rating

Rating for group and individual non-grandfathered policies will be based on 4 factors.

4 FACTORS



There is no health or gender rating for enrollees.

**<https://www.federalregister.gov/articles/2012/11/26/2012-28428/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review>



**ALL NON-GRANDFATHERED
INDIVIDUAL POLICIES WILL
BE GUARANTEED ISSUE**

Starting January 1st, 2014

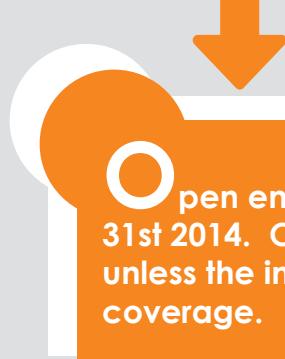


THIS MEANS

- 1.** An individual cannot be denied a policy based on health conditions.
- 2.** They will also have no pre-existing waiting period.
- 3.** Individual policies will have no exclusion riders or declinations.



These changes will be effective for all new policies starting with **1/1/14** effective dates and effective upon renewal starting **1/1/14** for in force non-grandfathered policies.



Open enrollment for 2014 will be October 2013-March 31st 2014. Outside those times, enrollment will be closed unless the individual has a qualifying event such as a loss of coverage.



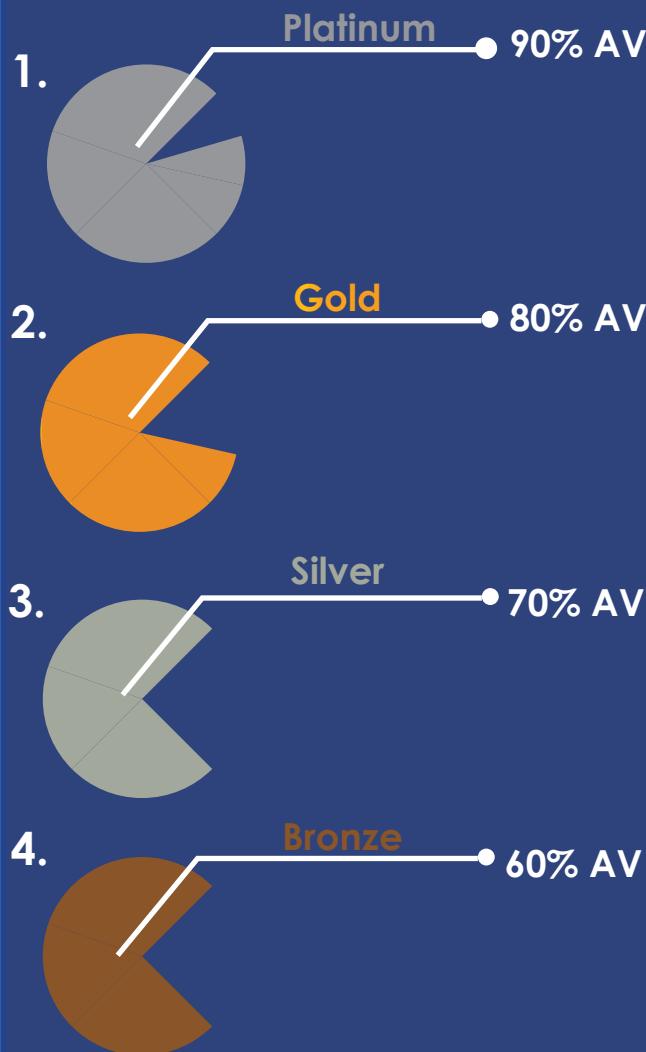
Affordable Care Act Insurance Plans Metal Plans & Actuarial Value

All non-grandfathered plans will fall into four “**Metal**” tiers based on the plan's Actuarial Value (AV).

- The Actuarial Value of a plan is defined as the total average cost for covered benefits that a plan will cover.

These classifications were created to make it easier for consumers to compare plans across carriers. Comparing plans within the same AV would help the consumer to know what type of coverage they are purchasing.

4 ACA METAL PLANS



NOTE

A plan can vary within **2%** above or below this percentage and still be considered in compliance.

- For example, if a plan has an AV of 68%-72%, it's still considered a silver plan.

**<http://www.healthcare.gov/news/factsheets/2012/11/eh-b11202012a.html>



Each state chooses whether they would like to setup their own Marketplace or choose the Federal version.

PRIVATE MARKETPLACE OR FEDERAL?



There is also the option to establish a partnership exchange where the state uses the federal version for a number of years and transitions to a state run exchange in future years.

- It's important to note that this is primarily going to consist of a website set up by the government where private insurance companies will sell their plans.
- If individuals would like access to their tax subsidies, they will have to purchase through the public marketplace.
- There is no government plan being offered. All plans will be offered by private insurance companies.
- Your insurance agent can also help guide you through the process and help you pick the right plan for your family.

** <http://www.healthcare.gov/marketplace/about/index.html>



INDIVIDUAL

Premium Tax Subsidy



Starting January 1st, 2014, individuals can access a premium tax subsidy if they purchase on the Public Marketplace.

- The level of subsidy varies by income level.
- Premiums cannot exceed a percentage of annual household income.
- The premium subsidy is applied to the premium for the silver plan.

Premium Caps as a Percentage of Federal Poverty Level

Income as a % of FPL	Federal Caps on Premium
0-133%	2% of Income
133-150%	3-4% of Income
150-200%	4-6.3% of Income
200-250%	6.3-8.05% of Income
250-300%	8.05-9.5% of Income
300-400%	9.5% of Income

Estimated Income Corresponding to Federal Poverty Level In 2014

Household Size	133% FPL	400% FPL
1	\$15,370	\$46,226
2	\$20,762	\$62,441
3	\$26,153	\$78,657
4	\$31,545	\$94,972
5	\$37,937	\$111,087
6	\$42,328	\$127,303



ACCESSING the Subsidy



REMINDER

The 9.5% of annual household income
DOES NOT INCLUDE the dependent **OR** spouse's
portion of premium.

It only looks at the employee only contribution.
**<http://www.irs.gov/pub/irs-drop/n-11-73.pdf>

IF an employer provides coverage that is
affordable

meaning the employee only portion of
premium does not exceed 9.5% of annual
household income

THEN the employee is
not eligible to access any subsidy
through the public marketplace,
even if they make less than 400% FPL.



INDIVIDUAL MANDATE



WHILE FILING TAXES EACH YEAR

- Individuals must prove on their personal taxes that they have essential minimum coverage or face a penalty.
- Penalties will be phased in, with the full penalty being assessed starting in 2016.
- Fines will be adjusted annually for inflation in future years.

MONTHLY FINES WILL BE ASSESSED

- For any month you don't have coverage.
- Having coverage for one day of the month counts as having coverage for the entire month.

**[http://healthreformgps.org/
wp-content/uploads/CRS-report
onPPACAug2011.pdf](http://healthreformgps.org/wp-content/uploads/CRS-reportonPPACAug2011.pdf)

Healthcare Penalty

2014

\$95.00 per adult
\$47.50 per child
(up to \$285 per family)
or 1.0% of family income
whichever is greater.

2015

\$325.00 per adult and
\$162.50 per child
(up to \$975 per family)
or 2.0% of family income
whichever is greater.

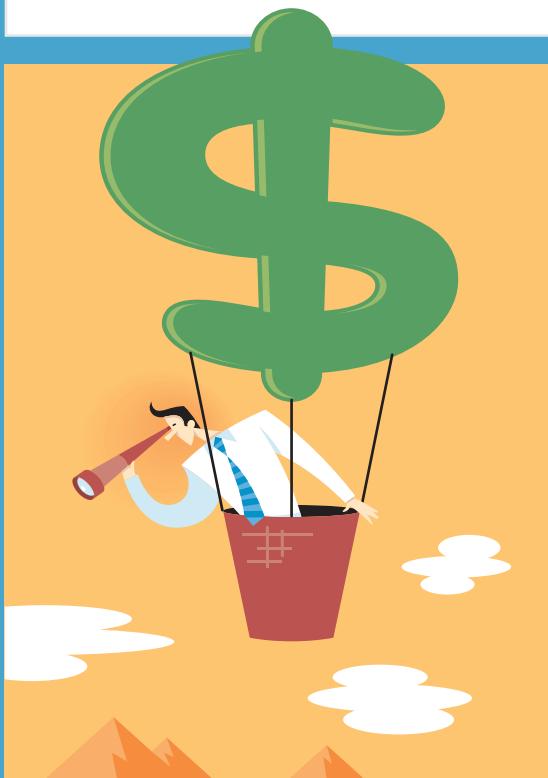
2016

\$695.00 per adult and
\$347.50 per child
(up to \$2,085 for a family)
or 2.5% of family income
whichever is greater.

The penalty is pro-rated by the number of months without coverage; there is no penalty for a single gap in coverage less than 3 months in a year.



Essential Health Benefit Out-of-Pocket Maximums



Non-Grandfathered Plans

Both **Group & Individual** that cover essential health benefits

MUST limit annual cost sharing to coordinate with the health savings account maximums.
**<http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-av-accred-final-2-25-2013v2.pdf>



COST SHARING is defined as deductible, coinsurance and copayments for in-network services.

In 2014,

these amounts are limited to:



\$6,350 for an individual



\$12,700 for families.



Small Group Deductible Limits



Starting January 1st, 2014

All new groups and upon renewal for in force groups, there will be deductible limits placed on small groups (2-50 lives).

- **Individual Limit** is \$2,000
- **Family Limit** is \$4,000

Exceptions will be made for plans that do not meet the minimum 60% Actuarial Value.

**<http://www.dol.gov/ebsa/faqs/faq-aca12.html>

Effective December 31st, 2017

Cadillac Tax

- Insurers of groups that exceed \$10,200 in premium for an individual or \$27,500 for a family will face an excise tax of 40%.
- This tax will be assessed to the insurance companies but expected to be passed onto the group.
- This amount will be adjusted for inflation starting in 2019.



Summary of ACA Fees:

PCORI (Patient Center Outreach Research Institute):

This institute is a non-for-profit center to promote the use of evidence-based medicine by disseminating comparative clinical effectiveness research findings. Charge on health insurance policies and employers that sponsor self-insured plans.

- ▶ Charge is \$1 per covered life starting with effective dates October 1st, 2012.
- ▶ Fees raise to \$2 per covered life for policy years renewing or starting October 1st, 2013.
- ▶ The program will end on October 1st, 2019.

\$
Health
Insurer
Fee:

Under the law, beginning January 1st, 2014

Health insurers will be assessed new federal taxes in the form of an annual fee. These aggregate fees were put in place to help subsidize the cost of the Affordable Care Act's many provisions.

- ▶ The fee will be approximately \$8 billion total in 2014 increasing to \$14.3 billion total in 2018.
- ▶ The amount that each health insurer owes will be determined annually based on its "net premiums written" - its share of the U.S. insurance market. Simply put, as a given insurer's market-share rises, so too will its' portion of the new fee.
- ▶ In May 2011, the Joint Committee on Taxation recognized this likely pass through effect, estimating that premiums would increase between 2.0 and 2.5 percent as a result of the insurer tax.

**<http://www.irs.gov/PUP/newsroom/REG-118315-12.pdf>

** <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>

\$
Transitional
Reinsurance
Fee:

Transitional Reinsurance Fee assesses a tax on group health plans for three years, starting in 2014, to help subsidize the individual guaranteed issue marketplace.

- ▶ The fund is estimated around \$12 billion in 2014 and phased out in 2016.
- ▶ HHS estimated the cost would be \$63 per year or \$5.25 per covered life per month, however this is pending final regulation.

**<http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs>

** <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>

On average the PCORI fees, the Health Insurer Fees and the Transitional Reinsurance fees add to around 4% of premium. This obviously will change per carrier but is a good benchmark.

This is for informational purposes only. Clients should consult an accountant and lawyer for final guidance. Please note information can change with no notice.

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